HOUSE BILL No. 1273

DIGEST OF INTRODUCED BILL

Citations Affected: IC 27-8-10.

Synopsis: ICHIA amendments. Amends the comprehensive health insurance association (ICHIA) law concerning: (1) membership; (2) premium rates; (3) assessments; (4) tax credits; (5) reporting requirements; and (6) member grievances. Makes technical corrections and conforming amendments. Repeals a section requiring annual reporting concerning tax credits. Makes an appropriation.

Effective: January 1, 2004 (retroactive); July 1, 2004; January 1, 2005.

Fry

January 15, 2004, read first time and referred to Committee on Insurance, Corporations and Small Business.

Introduced

Second Regular Session 113th General Assembly (2004)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2003 Regular Session of the General Assembly.

HOUSE BILL No. 1273

A BILL FOR AN ACT to amend the Indiana Code concerning insurance and to make an appropriation.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 27-8-10-1, AS AMENDED BY P.L.193-2003, SECTION 3, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2004]: Sec. 1. (a) The definitions in this section apply throughout this chapter.

(b) "Association" means the Indiana comprehensive health insurance association established under section 2.1 of this chapter.

(c) "Association policy" means a policy issued by the association that provides coverage specified in section 3 of this chapter. The term does not include a Medicare supplement policy that is issued under section 9 of this chapter.

(d) "Carrier" means an insurer providing medical, hospital, or surgical expense incurred health insurance policies.

(e) "Church plan" means a plan defined in the federal Employee Retirement Income Security Act of 1974 under 26 U.S.C. 414(e).

(f) "Commissioner" refers to the insurance commissioner.

(g) "Creditable coverage" has the meaning set forth in the federal Health Insurance Portability and Accountability Act of 1996 (26 U.S.C.

9801(c)(1)).

(h) "Eligible expenses" means those charges for health care services and articles provided for in section 3 of this chapter.

(i) "Federal income poverty level" has the meaning set forth in IC 12-15-2-1.

(j) "Federally eligible individual" means an individual:

(1) for whom, as of the date on which the individual seeks coverage under this chapter, the aggregate period of creditable coverage is at least eighteen (18) months and whose most recent prior creditable coverage was under a:

(A) group health plan;

(B) governmental plan; or

(C) church plan;

or health insurance coverage in connection with any of these plans;

(2) who is not eligible for coverage under:

(A) a group health plan;

(B) Part A or Part B of Title XVIII of the federal Social Security Act; or

(C) a state plan under Title XIX of the federal Social Security Act (or any successor program);

and does not have other health insurance coverage;

(3) with respect to whom the individual's most recent coverage was not terminated for factors relating to nonpayment of premiums or fraud;

(4) who, if after being offered the option of continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (29 U.S.C. 1191b(d)(1)), or under a similar state program, elected such coverage; and

(5) who, if after electing continuation coverage described in subdivision (4), has exhausted continuation coverage under the provision or program.

(k) "Governmental plan" means a plan as defined under the federal Employee Retirement Income Security Act of 1974 (26 U.S.C. 414(d)) and any plan established or maintained for its employees by the United States government or by any agency or instrumentality of the United States government.

(l) "Group health plan" means an employee welfare benefit plan (as defined in 29 U.S.C. 1167(1)) to the extent that the plan provides medical care payments to, or on behalf of, employees or their dependents, as defined under the terms of the plan, directly or through insurance, reimbursement, or otherwise.

(m) "Health care facility" means any institution providing health care services that is licensed in this state, including institutions engaged principally in providing services for health maintenance organizations or for the diagnosis or treatment of human disease, pain, injury, deformity, or physical condition, including a general hospital, special hospital, mental hospital, public health center, diagnostic center, treatment center, rehabilitation center, extended care facility, skilled nursing home, nursing home, intermediate care facility, tuberculosis hospital, chronic disease hospital, maternity hospital, outpatient clinic, home health care agency, bioanalytical laboratory, or central services facility servicing one (1) or more such institutions.

(n) "Health care institutions" means skilled nursing facilities, home health agencies, and hospitals.

(o) "Health care provider" means any physician, hospital, pharmacist, or other person who is licensed in Indiana to furnish health care services.

(p) "Health care services" means any services or products included in the furnishing to any individual of medical care, dental care, or hospitalization, or incident to the furnishing of such care or hospitalization, as well as the furnishing to any person of any other services or products for the purpose of preventing, alleviating, curing, or healing human illness or injury.

(q) "Health insurance" means hospital, surgical, and medical expense incurred policies, nonprofit service plan contracts, health maintenance organizations, limited service health maintenance organizations, and self-insured plans. **The term includes the following:**

(1) Supplemental and specified disease policies.

(2) Short term medical policies.

(3) Long term care policies.

(4) Long term disability policies.

(5) Accident only policies.

(6) Health and medical rider policies that are purchased separately.

(7) Stand alone mental health policies.

However, the term ~~"health insurance"~~ does not include short term travel accident policies, ~~accident only policies, fixed indemnity policies,~~ **credit insurance, dental insurance, vision insurance, worker's compensation or similar insurance,** automobile medical payment, or ~~incidental coverage issued with or as a supplement to liability insurance~~ **an extension of general liability coverage.**

(r) "Insured" means all individuals who are provided qualified

comprehensive health insurance coverage under an individual policy, including all dependents and other insured persons, if any.

(s) "Medicaid" means medical assistance provided by the state under the Medicaid program under IC 12-15.

(t) "Medical care payment" means amounts paid for:

(1) the diagnosis, care, mitigation, treatment, or prevention of disease or amounts paid for the purpose of affecting any structure or function of the body;

(2) transportation primarily for and essential to Medicare services referred to in subdivision (1); and

(3) insurance covering medical care referred to in subdivisions (1) and (2).

(u) "Medically necessary" means health care services that the association has determined:

(1) are recommended by a legally qualified physician;

(2) are commonly and customarily recognized throughout the physician's profession as appropriate in the treatment of the patient's diagnosed illness; and

(3) are not primarily for the scholastic education or vocational training of the provider or patient.

(v) "Medicare" means Title XVIII of the federal Social Security Act (42 U.S.C. 1395 et seq.).

(w) "Policy" means a contract, policy, or plan of health insurance.

(x) "Policy year" means a twelve (12) month period during which a policy provides coverage or obligates the carrier to provide health care services.

(y) "Health maintenance organization" has the meaning set out in IC 27-13-1-19.

(z) "Resident" means an individual who is:

(1) legally domiciled in Indiana for at least twelve (12) months before applying for an association policy; or

(2) a federally eligible individual and legally domiciled in Indiana.

(aa) "Self-insurer" means an employer who provides services, payment for, or reimbursement of any part of the cost of health care services other than payment of insurance premiums or subscriber charges to a carrier. However, the term "self-insurer" does not include an employer who is exempt from state insurance regulation by federal law, or an employer who is a political subdivision of the state of Indiana.

(bb) "Services of a skilled nursing facility" means services that must commence within fourteen (14) days following a confinement of at

least three (3) consecutive days in a hospital for the same condition.

(cc) "Skilled nursing facility", "home health agency", "hospital", and "home health services" have the meanings assigned to them in 42 U.S.C. 1395x.

(dd) "Medicare supplement policy" means an individual policy of accident and sickness insurance that is designed primarily as a supplement to reimbursements under Medicare for the hospital, medical, and surgical expenses of individuals who are eligible for Medicare benefits.

(ee) "Limited service health maintenance organization" has the meaning set forth in IC 27-13-34-4.

SECTION 2. IC 27-8-10-2.1, AS AMENDED BY P.L.178-2003, SECTION 63, AND P.L.193-2003, SECTION 4, IS CORRECTED AND AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2005]: Sec. 2.1. (a) There is established a nonprofit legal entity to be referred to as the Indiana comprehensive health insurance association, which must assure that health insurance is made available throughout the year to each eligible Indiana resident applying to the association for coverage. All carriers, health maintenance organizations, limited service health maintenance organizations, and self-insurers providing health insurance or health care services in Indiana must be members of the association. The association shall operate under a plan of operation established and approved under subsection (c) and shall exercise its powers through a board of directors established under this section.

(b) The board of directors of the association consists of ~~*seven (7)*~~ *nine (9)* members whose principal residence is in Indiana selected as follows:

(1) ~~*Three (3)*~~ *Four (4)* members to be appointed by the commissioner from the members of the association, one (1) of which must be a representative of a health maintenance organization.

(2) Two (2) members to be appointed by the commissioner shall be consumers representing policyholders.

(3) Two (2) members shall be the state budget director or designee and the commissioner of the department of insurance or designee.

(4) One (1) member to be appointed by the commissioner must be a representative of health care providers.

The commissioner shall appoint the chairman of the board, and the board shall elect a secretary from its membership. The term of office of each appointed member is three (3) years, subject to eligibility for

reappointment. Members of the board who are not state employees may be reimbursed from the association's funds for expenses incurred in attending meetings. The board shall meet at least semiannually, with the first meeting to be held not later than May 15 of each year.

(c) The association shall submit to the commissioner a plan of operation for the association and any amendments to the plan necessary or suitable to assure the fair, reasonable, and equitable administration of the association. The plan of operation becomes effective upon approval in writing by the commissioner consistent with the date on which the coverage under this chapter must be made available. The commissioner shall, after notice and hearing, approve the plan of operation if the plan is determined to be suitable to assure the fair, reasonable, and equitable administration of the association and provides for the sharing of association losses on an equitable, proportionate basis among the member carriers, health maintenance organizations, limited service health maintenance organizations, and self-insurers. If the association fails to submit a suitable plan of operation within one hundred eighty (180) days after the appointment of the board of directors, or at any time thereafter the association fails to submit suitable amendments to the plan, the commissioner shall adopt rules under IC 4-22-2 necessary or advisable to implement this section. These rules are effective until modified by the commissioner or superseded by a plan submitted by the association and approved by the commissioner. The plan of operation must:

(1) establish procedures for the handling and accounting of assets and money of the association;

(2) establish the amount and method of reimbursing members of the board;

(3) establish regular times and places for meetings of the board of directors;

(4) establish procedures for records to be kept of all financial transactions and for the annual fiscal reporting to the commissioner;

(5) establish procedures whereby selections for the board of directors will be made and submitted to the commissioner for approval;

(6) contain additional provisions necessary or proper for the execution of the powers and duties of the association; and

(7) establish procedures for the periodic advertising of the general availability of the health insurance coverages from the association.

(d) The plan of operation may provide that any of the powers and

duties of the association be delegated to a person who will perform functions similar to those of this association. A delegation under this section takes effect only with the approval of both the board of directors and the commissioner. The commissioner may not approve a delegation unless the protections afforded to the insured are substantially equivalent to or greater than those provided under this chapter.

(e) The association has the general powers and authority enumerated by this subsection in accordance with the plan of operation approved by the commissioner under subsection (c). The association has the general powers and authority granted under the laws of Indiana to carriers licensed to transact the kinds of health care services or health insurance described in section 1 of this chapter and also has the specific authority to do the following:

(1) Enter into contracts as are necessary or proper to carry out this chapter, subject to the approval of the commissioner.

(2) Sue or be sued, including taking any legal actions necessary or proper for recovery of any assessments for, on behalf of, or against participating carriers.

(3) Take legal action necessary to avoid the payment of improper claims against the association or the coverage provided by or through the association.

(4) Establish a medical review committee to determine the reasonably appropriate level and extent of health care services in each instance.

(5) Establish appropriate rates, scales of rates, rate classifications and rating adjustments, such rates not to be unreasonable in relation to the coverage provided and the reasonable operational expenses of the association.

(6) Pool risks among members.

(7) Issue policies of insurance on an indemnity or provision of service basis providing the coverage required by this chapter.

(8) Administer separate pools, separate accounts, or other plans or arrangements considered appropriate for separate members or groups of members.

(9) Operate and administer any combination of plans, pools, or other mechanisms considered appropriate to best accomplish the fair and equitable operation of the association.

(10) Appoint from among members appropriate legal, actuarial, and other committees as necessary to provide technical assistance in the operation of the association, policy and other contract design, and any other function within the authority of the

association.

(11) Hire an independent consultant.

(12) Develop a method of advising applicants of the availability of other coverages outside the association. ~~*and may promulgate a list of health conditions the existence of which would deem an applicant eligible without demonstrating a rejection of coverage by one (1) carrier.*~~

(13) Provide for the use of managed care plans for insureds, including the use of:

(A) health maintenance organizations; and

(B) preferred provider plans.

(14) Solicit bids directly from providers for coverage under this chapter.

(f) ~~*The board shall obtain an actuarial recommendation for development of an equitable methodology for determination of member assessments.*~~

~~*(g)*~~ Rates for coverages issued by the association may not be unreasonable in relation to the benefits provided, the risk experience, and the reasonable expenses of providing the coverage. Separate scales of premium rates based on age apply for individual risks. Premium rates must take into consideration the extra morbidity and administration expenses, if any, for risks insured in the association. The rates for a given classification may ~~*not*~~ be:

(1) not more than one hundred fifty percent (150%) of the average premium rate for that class charged by the five (5) carriers with the largest premium volume in the state during the preceding calendar year *for an insured whose family income is less than three hundred fifty-one percent (351%) of the federal income poverty level for the same size family; and*

(2) an amount equal to:

(A) not less than one hundred fifty-one percent (151%); and

(B) not more than two hundred percent (200%);

of the average premium rate for that class charged by the five (5) carriers with the largest premium volume in the state during the preceding calendar year, for an insured whose family income is more than three hundred fifty percent (350%) of the federal income poverty level for the same size family.

Additionally, the association may, on July 1 of each year, adjust the rates as described in section 2.2 of this chapter. In determining the average rate of the five (5) largest carriers, the rates charged by the carriers shall be actuarially adjusted to determine the rate that would have been charged for benefits **substantially** identical to those issued

by the association. All rates adopted by the association must be submitted to the commissioner for approval.

(g) ~~*(h)*~~ Following the close of the association's fiscal year, the association shall determine the net premiums, the expenses of administration, and the incurred losses for the year. **The following may not be included in the calculation of any net loss under this subsection:**

(1) The expenses of administration.

(2) Any loss incurred due to claims paid under an association policy for health care services provided to an insured in excess of one million five hundred thousand dollars ($1,500,000) during the insured's lifetime.

Forty percent (40%) of any net loss **and one hundred percent (100%) of the expenses of administration of the association** shall be assessed by the association to all members in proportion to their respective shares of total health insurance premiums **as reported to the department of insurance,** excluding premiums for Medicaid contracts with the state of Indiana, received in Indiana during the calendar year (or with paid losses in the year) coinciding with or ending during the fiscal year of the association. ~~or any other equitable basis as may be provided in the plan of operation. *For self-insurers, health maintenance organizations, and limited service health maintenance organizations that are members of the association, the proportionate share of losses must be determined through the application of an equitable formula based upon claims paid, excluding claims for Medicaid contracts with the state of Indiana, or the value of services provided.*~~ **Sixty percent (60%) of any net loss and one hundred percent (100%) of any loss described in subdivision (2) shall be paid by the department of insurance from the appropriation made under subsection (p).** In sharing losses, the association may abate or defer in any part the assessment of a member, if, in the opinion of the board, payment of the assessment would endanger the ability of the member to fulfill its contractual obligations. The association may also provide for interim assessments against members of the association if necessary to assure the financial capability of the association to meet the incurred or estimated claims expenses or operating expenses of the association until the association's next fiscal year is completed. *Except as provided in sections 12 and 13 of this chapter,* net gains, if any, must be held at interest to offset future losses or allocated to reduce future premiums. Assessments must be determined by the board members specified in subsection (b)(1), subject to final approval by the commissioner.

(h) ~~*(i)*~~ The association shall conduct periodic audits to assure the general accuracy of the financial data submitted to the association, and the association shall have an annual audit of its operations by an independent certified public accountant.

(i) ~~*(j)*~~ The association is subject to examination by the department of insurance under IC 27-1-3.1. The board of directors shall submit, not later than March 30 of each year, a financial report for the preceding calendar year in a form approved by the commissioner.

(j) ~~*(k)*~~ All policy forms issued by the association must conform in substance to prototype forms developed by the association, must in all other respects conform to the requirements of this chapter, and must be filed with and approved by the commissioner before their use.

(k) ~~*(l)*~~ The association may not issue an association policy to any individual who, on the effective date of the coverage applied for, does not meet the eligibility requirements of section 5.1 of this chapter.

~~*(l) The association shall pay an agent's insurance producer's referral fee of twenty-five dollars ($25) to each insurance agent producer who refers an applicant to the association if that applicant is accepted.*~~

~~(m)~~ **(l)** The association and the premium collected by the association shall be exempt from the premium tax, the adjusted gross income tax, or any combination of these upon revenues or income that may be imposed by the state.

~~(n)~~ **(m)** Members who ~~after July 1, 1983,~~ during any calendar year, have paid one (1) or more assessments levied under this chapter may ~~either:~~

~~(1) take a credit against premium taxes, adjusted gross income taxes, or any combination of these, or similar taxes upon revenues or income of member insurers that may be imposed by the state, up to the amount of the taxes due for each calendar year in which the assessments were paid and for succeeding years until the aggregate of those assessments have been offset by either credits against those taxes or refunds from the association; or~~

~~(2)~~ ~~any member insurer may~~ include in the rates for premiums charged for insurance policies to which this chapter applies amounts sufficient to recoup a sum equal to the amounts paid to the association by the member less any amounts returned to the member insurer by the association, and the rates shall not be deemed excessive by virtue of including an amount reasonably calculated to recoup assessments paid by the member.

~~(o)~~ **(n)** The association shall provide for the option of monthly collection of premiums.

(o) The association shall annually certify to the department of insurance the amount necessary to pay sixty percent (60%) of any net loss and one hundred percent (100%) of any loss described in subsection (g)(2), as specified in subsection (g);

(p) There is annually appropriated from the state general fund to the department of insurance an amount sufficient to pay the amount certified under subsection (o).

SECTION 3. IC 27-8-10-2.2 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2004]: **Sec. 2.2. (a) Subject to subsection (b), a premium rate calculated under section 2.1 of this chapter may, on July 1 of each year, be adjusted by an amount equal to:**

(1) the percentage change in medical cost experienced by the association; minus

(2) the percentage change in the Indiana medical care component of the Consumer Price Index for all Urban Consumers, as published by the United States Bureau of Labor Statistics;

during the preceding calendar year.

(b) A positive or negative adjustment in the rate calculated under subsection (a) may not be greater than ten percent (10%).

SECTION 4. IC 27-8-10-2.3, AS ADDED BY P.L.167-2002, SECTION 1, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2004]: Sec. 2.3. A member shall, not later than October 31 of each year, certify an independently audited report to the:

(1) association;

(2) legislative council; and

(3) department of insurance;

of the amount of tax credits taken against assessments by the member under section ~~2.1(n)(1)~~ **2.1** of this chapter during the previous calendar year.

SECTION 5. IC 27-8-10-2.4 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2004]: **Sec. 2.4. (a) A member shall comply with the association's plan of operation.**

(b) A member assessment under section 2.1 of this chapter is due not more than thirty (30) days after the member receives written notice of the assessment. A member that pays an assessment after the due date shall pay interest on the assessment at the rate of six percent (6%) per annum.

SECTION 6. IC 27-8-10-2.5 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY

1, 2004]: **Sec. 2.5. (a) If a member is aggrieved by an act of the association, the member shall, not more than ninety (90) days after the act occurs, appeal to the board of directors for review of the act.**

(b) If:

(1) within thirty (30) days after an appeal is filed under subsection (a), the board of directors has not acted on the appeal; or

(2) a member is aggrieved by a final action or decision of the board of directors;

the member may appeal to the commissioner.

(c) An appeal to the commissioner under subsection (b) must be filed less than thirty (30) days after the:

(1) expiration of the thirty (30) day period specified in subsection (b)(1); or

(2) action or decision specified in subsection (b)(2).

(d) A final action or order of the commissioner on an appeal filed under this section is subject to judicial review.

SECTION 7. IC 27-8-10-12, AS ADDED BY P.L.193-2003, SECTION 9, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2004]: Sec. 12. (a) As used in this section, "office" refers to the office of Medicaid policy and planning established by IC 12-8-6-1.

(b) As used in this section, "provider" means an individual, a partnership, a corporation, or a governmental entity that is enrolled in the Medicaid program under rules adopted under IC 4-22-2 by the office.

(c) The association and the office shall jointly consider the use of all or a part of:

(1) assessments made under this chapter; or

(2) funds, if any, realized by the state due to a reduction in tax credits taken under this chapter;

as the nonfederal share of payments under a payment program described in subsection (d).

(d) In conjunction with the joint efforts described in subsection (c), the association and the office shall consider and, if feasible, develop Medicaid payment programs that, using funding described in subsection (c):

(1) provide Medicaid add-on payments to providers or affiliated entities of providers on the basis of the provider's provision of care to individuals covered under an association policy; or

(2) to the extent not prohibited by applicable federal Medicaid law, condition a provider's Medicaid payment on the provider's

remittance of funds to the association or another nongovernmental entity established to fund care to individuals covered under an association policy.

(e) If mutually agreed, the association and the office may implement a payment program developed under subsection (d) following approval of a Medicaid state plan amendment by the federal Centers for Medicare and Medicaid Services.

(f) If:

(1) federal financial participation is disallowed by the federal Centers for Medicare and Medicaid Services for the funds used as the nonfederal share of a Medicaid payment made under a program developed under this section; and

(2) the office is required to pay to the federal Centers for Medicare and Medicaid Services a refund of the federal financial participation described in subdivision (1);

the provider receiving the Medicaid payment described in subdivision (1) shall refund to the office the federal financial participation described in subdivision (2) not less than five (5) business days before the date that the office's payment described in subdivision (2) is required to be made to the federal Centers for Medicare and Medicaid services. The elections under IC 12-15-13-3(b) do not apply to a notice directing a provider to pay a refund required of the provider under this subsection.

(g) Notwithstanding section 3 of this chapter, subject to applicable federal Medicaid requirements, the rate of provider reimbursement for a health care service following implementation of a payment program under this section must be an amount determined by the association, according to standards and criteria relied upon by the association, to be equal to the greater of the:

(1) Medicare reimbursement rate for the health care service plus ten percent (10%); or

(2) lowest prevailing rate of reimbursement for the health care service in Indiana under a commercial health insurance policy.

(h) Notwithstanding ~~section 2.1(h)~~ **section 2.1** of this chapter, if a payment program is implemented under this section, the board shall determine member assessments in an amount sufficient to ensure a net gain and distributions provided for under section 13 of this chapter.

(i) Assessments made under this chapter may be adjusted by the board to ensure that the assessments are not impermissible health care related taxes under 42 U.S.C. 1396b(w), as amended.

SECTION 8. IC 27-8-10-13, AS ADDED BY P.L.193-2003, SECTION 10, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE

JULY 1, 2004]: Sec. 13. (a) This section applies beginning in the calendar year immediately following the calendar year during which a program described in section 12 of this chapter is implemented.

(b) As used in this section, "net gain" means any funds retained by the association and a nongovernmental entity described in section 12(d)(2) of this chapter after all expenses are paid.

(c) If the association experiences a net gain in any calendar year, a member that:

(1) is a nonprofit entity not subject to taxation described in section ~~2.1(n)~~ **2.1** of this chapter; and

(2) paid an assessment under this chapter during the calendar year in which the net gain occurred;

is eligible to receive a distribution from the association during the immediately succeeding calendar year. **This subsection expires December 31, 2009.**

(d) The amount of a distribution to an eligible member under subsection (c) is equal to the eligible member's proportionate share of the net gain not to exceed fifty percent (50%) of the amount of the assessment the member paid during the calendar year in which the net gain occurred. **This subsection expires December 31, 2009.**

(e) An eligible member may submit a claim for a distribution under this section in the manner and form specified by the association.

(f) After distributions are made to eligible members under subsection (c), any remaining net gain shall be distributed as follows:

(1) Forty percent (40%) must be distributed to the office of Medicaid policy and planning established by IC 12-8-6-1.

(2) Forty percent (40%) must be distributed to members according to each member's proportionate share of the total assessment amount paid by the members that has not been offset by:

(A) credits against taxes or refunds from the association under section ~~2.1(n)~~ **2.1** of this chapter; or

(B) distributions under subsection (c).

(3) Ten percent (10%) must be held in reserve by the association to assist in funding payments to providers.

(4) Ten percent (10%) must be allocated by the association to reduce premiums.

This subsection expires December 31, 2009.

(g) Beginning January 1, 2010, any net gain shall be distributed as follows:

(1) Forty percent (40%) must be distributed to the office of Medicaid policy and planning established by IC 12-8-6-1.

(2) Forty percent (40%) must be distributed to members according to each member's proportionate share of the total assessment amount paid by the members.

(3) Ten percent (10%) must be held in reserve by the association to assist in funding payments to providers.

(4) Ten percent (10%) must be allocated by the association to reduce premiums.

~~(f)~~ **(h)** The association shall make distributions under this section according to written guidelines established by the association.

SECTION 9. IC 27-8-10-14, AS ADDED BY P.L.193-2003, SECTION 11, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JANUARY 1, 2004 (RETROACTIVE)]: Sec. 14. (a) Notwithstanding section 2.1 of this chapter: ~~for the period beginning July 1, 2003, and ending March 15, 2004.~~

(1) fifty percent (50%) of any net loss determined under ~~section 2.1(g)~~ **section 2.1** of this chapter shall be assessed by the association to all members in proportion to their respective shares of total health insurance premiums, excluding premiums for Medicaid contracts with the state, received in Indiana during the calendar year (or with paid losses in the year) coinciding with or ending during the fiscal year of the association; and

(2) fifty percent (50%) of any net loss determined under ~~section 2.1(g)~~ **section 2.1** of this chapter shall be assessed by the association to all members in proportion to their respective shares of the number of individuals in Indiana who are covered under health insurance provided by a member, excluding individuals who are covered under Medicaid contracts with the state during the calendar year coinciding with or ending during the fiscal year of the association.

(b) This section expires ~~March 15, 2004.~~ **January 1, 2005.**

SECTION 10. IC 27-8-10-2.3 IS REPEALED [EFFECTIVE JANUARY 1, 2005].

SECTION 11. [EFFECTIVE JULY 1, 2004] **(a) Beginning January 1, 2005, a member of the Indiana comprehensive health insurance association that, before January 1, 2005, has:**

(1) paid an assessment; and

(2) not taken a credit against taxes;

under IC 27-8-10-2.1, before amendment by this act, may take not more than twenty percent (20%) of the amount of the unused tax credit that exists on January 1, 2005, in each taxable year beginning January 1, 2005, and ending December 31, 2009.

(b) A member shall, not later than October 31 of each year,

certify an independently audited report to the:

(1) association;

(2) legislative council; and

(3) department of insurance;

of the amount of tax credits taken against assessments by the member under IC 27-8-10-2.1, before amendment by this act, and under this SECTION, during the previous calendar year. The report to the legislative council must be in an electronic format under IC 5-14-6.

(c) This SECTION expires December 31, 2010.

SECTION 12. **An emergency is declared for this act.**